		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040311

Facility Name: PRAIRIE VIEW CARE CENTER-CHARLESTON

Address: 716 EIGHTEENTH STREET (Number) CHARLESTON (City) 61920 (Zip Code)

County: COLES

Telephone Number: (847)674-4700 **Fax #** (847) 674-4733

IDPA ID Number: 37-1304215

Date of Initial License for Current Owners: 02/01/93

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: DON FIETS **Telephone Number:** (847) 674-4700 X40

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) BRADLEY ALTER
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRKUPNICK, BOKOR, KAGDA & BROOKS, LTD., 3750 W. DEVON AVE.,LINCOLNWOOD,IL 60712
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	45	Skilled (SNF)	45	16,425	1
2		Skilled Pediatric (SNF/PED)			2
3	94	Intermediate (ICF)	94	34,310	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	139	TOTALS	139	50,735	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,905	2,905	8
9	SNF/PED					9
10	ICF	23,066	7,759	493	31,318	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	23,066	7,759	3,398	34,223	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.45%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 2,905

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLE # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	132,943	15,897	7,205	156,045		156,045		156,045			1
2	Food Purchase		137,608		137,608		137,608	(334)	137,274			2
3	Housekeeping	72,472	23,932		96,404		96,404	455	96,859			3
4	Laundry	44,216	11,695	1,217	57,128		57,128		57,128			4
5	Heat and Other Utilities			118,638	118,638		118,638	1,381	120,019			5
6	Maintenance	37,192	22,346	16,486	76,024		76,024	70	76,094			6
7	Other (specify):*			7,508	7,508		7,508		7,508			7
8	**TOTAL General Services**	286,823	211,478	151,054	649,355		649,355	1,572	650,927			8
	B. Health Care and Programs											
9	Medical Director			5,500	5,500		5,500		5,500			9
10	Nursing and Medical Records	1,185,418	75,710	8,959	1,270,087		1,270,087	16,811	1,286,898			10
10a	Therapy	67,870	3,659	11,519	83,048		83,048		83,048			10a
11	Activities	47,986	1,852	336	50,174		50,174		50,174			11
12	Social Services	28,297		6,399	34,696		34,696		34,696			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,329,571	81,221	32,713	1,443,505		1,443,505	16,811	1,460,316			16
	C. General Administration											
17	Administrative	43,949		11,975	55,924		55,924	35,917	91,841			17
18	Directors Fees											18
19	Professional Services			70,211	70,211		70,211	(27,832)	42,379			19
20	Dues, Fees, Subscriptions & Promotions			19,178	19,178		19,178	(3,941)	15,237			20
21	Clerical & General Office Expenses	67,050	21,385	140,711	229,146		229,146	(59,205)	169,941			21
22	Employee Benefits & Payroll Taxes			338,273	338,273		338,273	(25,101)	313,172			22
23	Inservice Training & Education			1,499	1,499		1,499		1,499			23
24	Travel and Seminar			1,422	1,422		1,422	2,267	3,689			24
25	Other Admin. Staff Transportation			5,059	5,059		5,059	2,125	7,184			25
26	Insurance-Prop.Liab.Malpractice			57,818	57,818		57,818	1,680	59,498			26
27	Other (specify):*			5,084	5,084		5,084	(5,084)				27
28	**TOTAL General Administration**	110,999	21,385	651,230	783,614		783,614	(79,174)	704,440			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,727,393	314,084	834,997	2,876,474		2,876,474	(60,791)	2,815,683			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON #0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			37,816	37,816		37,816	167,598	205,414			30
31	Amortization of Pre-Op. & Org.							3,252	3,252			31
32	Interest			17,376	17,376		17,376	422,837	440,213			32
33	Real Estate Taxes			11,020	11,020		11,020		11,020			33
34	Rent-Facility & Grounds			591,144	591,144		591,144	(585,744)	5,400			34
35	Rent-Equipment & Vehicles			2,135	2,135		2,135	266	2,401			35
36	Other (specify):*											36
37	**TOTAL Ownership**			659,491	659,491		659,491	8,209	667,700			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		61,121	15,681	76,802		76,802		76,802			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			76,103	76,103		76,103		76,103			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		61,121	91,784	152,905		152,905		152,905			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,727,393	375,205	1,586,272	3,688,870		3,688,870	(52,582)	3,636,288			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,538)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(334)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(3,496)	21		18
19	Entertainment		20		19
20	Contributions	(1,743)	20		20
21	Owner or Key-Man Insurance	(47,900)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(5,084)	27		24
25	Fund Raising, Advertising and Promotional	(2,406)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule SEE PAGE 5A	(18,605)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (87,106)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	34,524		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 34,524		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (52,582)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS
PRAIRIE VIEW CARE CENTER-CHARLESTON
ID# 0040311
Report Period Beginning: 01/01/2002
Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 0	6	1
2	MARKETING SALARY	(16,599)	21	2
3	MARKETING TRAVEL	(2,006)	25	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(18,605)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(334)	0	0	0	0	0	0	0	0	0	0	(334)	2
3	Housekeeping	0	0	455	0	0	0	0	0	0	0	0	455	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,381	0	0	0	0	0	0	0	0	1,381	5
6	Maintenance	0	0	70	0	0	0	0	0	0	0	0	70	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(334)	0	1,906	0	0	0	0	0	0	0	0	1,572	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	16,811	0	0	0	0	0	0	0	0	16,811	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	16,811	0	0	0	0	0	0	0	0	16,811	16
	C. General Administration													
17	Administrative	0	(11,975)	47,892	0	0	0	0	0	0	0	0	35,917	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(32,410)	4,578	0	0	0	0	0	0	0	0	(27,832)	19
20	Fees, Subscriptions & Promotions	(4,149)	0	208	0	0	0	0	0	0	0	0	(3,941)	20
21	Clerical & General Office Expenses	(20,095)	(115,139)	76,029	0	0	0	0	0	0	0	0	(59,205)	21
22	Employee Benefits & Payroll Taxes	(47,900)	0	22,799	0	0	0	0	0	0	0	0	(25,101)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	2,267	0	0	0	0	0	0	0	0	2,267	24
25	Other Admin. Staff Transportation	(2,006)	0	4,131	0	0	0	0	0	0	0	0	2,125	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,680	0	0	0	0	0	0	0	0	1,680	26
27	Other (specify):*	(5,084)	0	0	0	0	0	0	0	0	0	0	(5,084)	27
28	**TOTAL General Administration**	(79,234)	(159,524)	159,584	0	0	0	0	0	0	0	0	(79,174)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(79,568)	(159,524)	178,301	0	0	0	0	0	0	0	0	(60,791)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,538)	172,926	2,210	0	0	0	0	0	0	0	0	167,598	30
31	Amortization of Pre-Op. & Org.	0	3,252	0	0	0	0	0	0	0	0	0	3,252	31
32	Interest	0	422,836	1	0	0	0	0	0	0	0	0	422,837	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(591,144)	5,400	0	0	0	0	0	0	0	0	(585,744)	34
35	Rent-Equipment & Vehicles	0	0	266	0	0	0	0	0	0	0	0	266	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(7,538)	7,870	7,877	0	0	0	0	0	0	0	0	8,209	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(87,106)	(151,654)	186,178	0	0	0	0	0	0	0	0	(52,582)	45

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SCHEDULE ATTACHED		CERTIFIED HEATLI	SKOKIE	MANAGEMENT/
				MANAGEMENT		BOOKKEEPING

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEES	$ 11,975	CERTIFIED HEALTH MANAGEMENT		$	$ (11,975)	1
2	V	21	BOOKKEEPING FEES	116,064				(116,064)	2
3	V	19	ADMIN CONSULTING FEES	32,410				(32,410)	3
4	V								4
5	V	34	RENT	591,144	PRAIRIE VIEW CARE CENTER OF CHARLESTON LLC			(591,144)	5
6	V	21	OFFICE EXPENSE				925	925	6
7	V	30	DEPRECIATION				172,926	172,926	7
8	V	31	AMORTIZATION				3,252	3,252	8
9	V	32	INTEREST				422,836	422,836	9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 751,593			$ 599,939	$ * (151,654)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	3	HOUSEKEEPING	$	CERTIFIED HEALTH MANAGEMENT		$ 455	$ 455	15
16	V	5	ELECTRIC & GAS				1,381	1,381	16
17	V	6	MAINTENANCE				70	70	17
18	V	10	NURSING/MEDICAL RECORDS				16,811	16,811	18
19	V	17	ADMIN SALARIES				47,892	47,892	19
20	V	19	PROFESSIONAL FEES				4,578	4,578	20
21	V	20	FEE, SUBSCRIPTIONS				208	208	21
22	V	21	OFFICE EXP.				76,029	76,029	22
23	V	22	EMPLOYEE BENEFITS				22,799	22,799	23
24	V	24	TRAVEL/SEMINAR				2,267	2,267	24
25	V	25	TRANSPORTATION				4,131	4,131	25
26	V	26	INSURANCE				1,680	1,680	26
27	V	30	DEPRECIATION				2,210	2,210	27
28	V	32	INTEREST				1	1	28
29	V	34	OFFICE RENT				5,400	5,400	29
30	V	35	EQUIPMENT RENTAL				266	266	30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 186,178	$ * 186,178	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLI # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BRADLEY ALTER		ADMINISTRATIVE					SALARY	$ 10,270	17-3	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 10,270		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CERTIFIED HEALTH MANAGEMENT
Street Address: 3856 OAKTON SUTIE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	PER PATIENT DAY	272,818	8	$ 3,625	$	34,223	$ 455	1
2	5	ELECTRIC & GAS	" " "	272,818	8	11,011		34,223	1,381	2
3	6	MAINTENANCE	" " "	272,818	8	557		34,223	70	3
4	10	NURSING/MEDICAL RECORD	" " "	272,818	8	134,010	134,010	34,223	16,811	4
5	17	ADMIN SALARIES	" " "	272,818	8	381,783	381,783	34,223	47,892	5
6	19	PROFESSIONAL FEES	" " "	272,818	8	36,495		34,223	4,578	6
7	20	FEE, SUBSCRIPTIONS	" " "	272,818	8	1,662		34,223	208	7
8	21	OFFICE EXP.	" " "	272,818	8	606,084	496,771	34,223	76,029	8
9	22	EMPLOYEE BENEFITS	" " "	272,818	8	181,747		34,223	22,799	9
10	24	TRAVEL/SEMINAR	" " "	272,818	8	18,072		34,223	2,267	10
11	25	TRANSPORTATION	" " "	272,818	8	32,928		34,223	4,131	11
12	26	INSURANCE	" " "	272,818	8	13,389		34,223	1,680	12
13	30	DEPRECIATION	" " "	272,818	8	17,618		34,223	2,210	13
14	32	INTEREST	" " "	272,818	8	9		34,223	1	14
15	34	OFFICE RENT	" " "	272,818	8	43,046		34,223	5,400	15
16	35	EQUIPMENT RENTAL	" " "	272,818	8	2,124		34,223	266	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,484,160	$ 1,012,564		$ 186,178	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PRAIRIE VIEW CARE CENTER CHARLESTO
Street Address: 3856 OAKTON SUITE 200
City / State / Zip Code: SKOKIE, IL 60076
Phone Number: ((847) 674-4700
Fax Number: ((847) 674-4733

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	OFFICE EXPENSE	DIRECT COSTS	1	1	$ 925	$	1	$ 925	1
2	30	DEPRECIATION		1	1	172,926		1	172,926	2
3	31	AMORTIZATION		1	1	3,252		1	3,252	3
4	32	INTEREST		1	1	422,836		1	422,836	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 599,939	$		$ 599,939	25

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLE # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	CIB BANK		X	MORTGAGE	$28,608.00	4/00	$ 2,974,908	$ 2,832,404	3/20	9.7500	$ 282,132	1
2	GERSHON BASSMAN	X		MORTGAGE	$12,176.00	4/00	1,282,288	1,216,098	3/20	9.7500	119,702	2
3	BANK FINANCIAL		X	MORTGAGE	$10,613.00		512,915	325,499	9/03	10.5000	21,002	3
4												4
5	URBANA CARE CENTER	X									1,213	5
	Working Capital											
6	CIB BANK		X	WORKING CAPITAL				360,891		PRIME+	15,053	6
7	AICC		X	INS FINANCE							1,110	7
8	RELATED PARTY	X		WORKING CAPITAL							1	8
9	TOTAL Facility Related				$51,397.00		$ 4,770,111	$ 4,734,892			$ 440,213	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,770,111	$ 4,734,892			$ 440,213	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 64,409	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 37,341	2
3. Under or (over) accrual (line 2 minus line 1).		$ (27,068)	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 38,088	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 11,020	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	69,093	8
	1998	63,100	9
	1999	62,000	10
	2000	63,146	11
	2001	37,341	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME PRAIRIE VIEW CARE CENTER-CHARLESTON COUNTY COLES

FACILITY IDPH LICENSE NUMBER 0040311

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	02-2-13403-000	NURSING HOME	$ 37,341.00	$ 37,341.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 37,341.00	$ 37,341.00

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: _____ B. General Construction Type: Exterior _____ Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 208,500	1
2					2
3	TOTALS			$ 208,500	3

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$ 3,753,000	$ 136,473	27.5	$ 136,473	$	$ 369,623	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASHOLD IMPROVEMENTS			1993	10,990	316	30	366	50	3,311	9
10	LEASHOLD IMPROVEMENTS			1994	18,622	477	39	477	0	3,931	10
11	CUBICLE CURTAIN, TILE, LIGHTS			1995	10,267	263	39	263	0	2,232	11
12	BATH/SHOWER REPAIR			1995	12,843	329	39	329	0	2,925	12
13	ROOF REPAIR			1995	2,005	51	39	51	0	433	13
14	WATER HEATER			1995	4,791	123	39	123	(0)	1,032	14
15	ALARM SYSTEM			1996	712	18	39	18	0	119	15
16	CARPET,TILE,BASE			1996	7,800	200	39	200		1,237	16
17	PARKING LOT REPAVING			1996	13,485	899	15	899		5,843	17
18	ARCHIETECT			1996	830	21	39	21	0	134	18
19	FRONT ENTRANCE REMODELING			1997	80,830	2,073	39	2,073	(0)	12,937	19
20	FRONT ENTRANCE SIDEWALK/LANDSCAPING			1997	12,255	314	39	314	0	2,722	20
21	FLOOR TILES			1998	10,365	266	39	266	(0)	1,319	21
22	ELECTRICAL WORK			1998	5,137	132	39	132	(0)	591	22
23	WINDOEW			1998	1,852	47	39	47	0	214	23
24	ELECTRICAL WORK			1999	1,482	38	39	38		150	24
25	ROOFTOP AC			1999	6,900	177	39	177	(0)	627	25
26	AIR CONDITIIONERS			2000	11,702	1,672	7	1,672	(0)	2,550	26
27	WATER HEATER			2000	3,378	123	27.5	123	(0)	251	27
28	FLOOR TILES			2001	2,365	86	27.5	86		129	28
29	HANDRAILS/BUMPER GUARDS			2001	13,965	508	27.5	508	(0)	762	29
30	WALLPAPER			2002	6,405	204	27.5	214	10	214	30
31	FLOOR TILES			2002	1,681	53	27.5	56	3	56	31
32	CONCRETE WORK			2002	3,629	49	27.5	55	6	55	32
33	?????????/			2002	3,583	49	27.5	54	5	54	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,000,874	$ 144,961		$ 145,036	$ 75	$ 413,452	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 154,325	$ 18,222	$ 15,433	$ (2,790)	8-10 YRS	$ 88,563	71
72	Current Year Purchases	17,184	7,984	1,718	(6,266)	5	1,718	72
73	Fully Depreciated Assets	46,498						73
74	RELATED PARTY		38,663	38,663		10 YRS		74
75	TOTALS	$ 218,007	$ 64,869	$ 55,814	$ (9,055)		$ 90,281	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINT,NURSING,ACTV	1997 FORD VAN	1999	$ 22,821	$ 3,122	$ 4,564	$ 1,442	5 YRS	$ 15,016	76
77										77
78										78
79										79
80	TOTALS			$ 22,821	$ 3,122	$ 4,564	$ 1,442		$ 15,016	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,450,202	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 212,952	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 205,414	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,538)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 518,749	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 2,135 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 1,951	$		$ 1,951	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			13,730			13,730	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				53,124		53,124	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): LABORATORY	39-2 39-2					5,418 2,579		5,418 2,579	13
14	TOTAL			$		$ 15,681	$ 61,121		$ 76,802	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON **#** 0040311 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 33,200)	696,544		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	24,163		6
7	Other Prepaid Expenses	3,000		7
8	Accounts Receivable (owners or related parties)	16,598		8
9	Other(specify): REAL ESTATE ESCROW	25,561		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 765,866	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	247,874		15
16	Equipment, at Historical Cost	240,828		16
17	Accumulated Depreciation (book methods)	(238,619)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 250,083	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,015,949	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 180,016	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,000		28
29	Short-Term Notes Payable	551,251		29
30	Accrued Salaries Payable	64,755		30
31	Accrued Taxes Payable (excluding real estate taxes)	6,341		31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,088		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 861,451	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 861,451	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 154,498	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,015,949	$	48

***(See instructions.)**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 208,180	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 208,180	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(53,682)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (53,682)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 154,498	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,562,194	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,562,194	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	71,078	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 71,078	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DISCOUNTS	2,210	28
28a	VENDING COMMISSIONS	406	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,616	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,635,888	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	649,355	31
32	Health Care	1,443,505	32
33	General Administration	783,614	33
	B. Capital Expense		
34	Ownership	659,491	34
	C. Ancillary Expense		
35	Special Cost Centers	76,802	35
36	Provider Participation Fee	76,103	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,688,870	40
41	**Income before Income Taxes (line 30 minus line 40)****	(52,982)	41
42	**Income Taxes**	700	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (53,682)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** TAX RETURN / CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,804	2,080	$ 45,402	$ 21.83	1
2	Assistant Director of Nursing	1,960	2,080	40,309	19.38	2
3	Registered Nurses	5,329	5,569	112,059	20.12	3
4	Licensed Practical Nurses	18,735	19,579	317,746	16.23	4
5	Nurse Aides & Orderlies	58,399	58,889	613,427	10.42	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,690	3,893	67,870	17.43	8
9	Activity Director	1,788	2,154	22,370	10.39	9
10	Activity Assistants	3,551	3,669	25,616	6.98	10
11	Social Service Workers	2,803	3,223	28,297	8.78	11
12	Dietician					12
13	Food Service Supervisor	1,968	2,080	21,185	10.19	13
14	Head Cook	7,917	8,363	66,041	7.90	14
15	Cook Helpers/Assistants	6,379	6,491	45,717	7.04	15
16	Dishwashers					16
17	Maintenance Workers	2,569	2,694	37,192	13.81	17
18	Housekeepers	9,069	9,455	72,472	7.66	18
19	Laundry	6,887	7,097	44,216	6.23	19
20	Administrator	1,976	2,080	43,949	21.13	20
21	Assistant Administrator					21
22	Other Administrative	738	1,040	16,599	15.96	22
23	Office Manager	2,032	2,080	37,990	18.26	23
24	Clerical	1,302	1,360	12,461	9.16	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,755	1,893	16,118	8.51	31
32	Other Health Ca CARE PLAN	1,920	2,040	37,942	18.60	32
33	Other(specify) TRANSP. AIDE			2,415		33
34	TOTAL (lines 1 - 33)	142,571	147,809	$ 1,727,393 *	$ 11.69	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	130	$ 5,806	1-3	35
36	Medical Director	monthly	5,500	9-3	36
37	Medical Records Consultant	12	371	10-3	37
38	Nurse Consultant	30	1,622	10-3	38
39	Pharmacist Consultant	monthly	2,259	10-3	39
40	Physical Therapy Consultant	31	1,263	10a-3	40
41	Occupational Therapy Consultant	72	2,888	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	180	7,368	10a-3	43
44	Activity Consultant	12	336	11-3	44
45	Social Service Consultant	185	6,399	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	652	$ 33,812		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	NONE	$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
GEORGIA RYAN	ADMIN	0	$ 43,949
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 43,949

B. Administrative - Other

Description	Amount
MANAGEMENT FEES	$ 11,975
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 11,975

C. Professional Services

Vendor/Payee	Type	Amount
SEE SCHEDULE ATTACHED		70,211
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 70,211

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,158
Unemployment Compensation Insurance	15,768
FICA Taxes	130,177
Employee Health Insurance	95,708
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	51
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	3,511
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	47,900
RELATED PARTY	22,799
INSURANCE - EXECUTIVE LIFE VI 21	(47,900)
TOTAL (agree to Schedule V, line 22, col.8)	$ 313,172

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	5,678
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	2,406
TRUST/FRANCHISE/CONTRIB/ETC	1,743
LICENSES & PERMITS	1,792
DUES & SUBSCRIPTIONS	7,359
RELATED PARTY	208
TRUST/FRANCHISE/CONTRIB/ETC	(1,743)
Less: Public Relations Expense	(0)
Non-allowable advertising	(2,406)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,237

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,422
Seminar Expense	
	0
RELATED PARTY	2,267
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,689

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7								N/A					
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON # 0040311 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **ILL CONUCIL LTC $6,233**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **76,103**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: PRAIRIE VIEW CARE CENTER-CHARLESTON #0040311 **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	5,806	
	REPAIRS & MAINTENANCE		1,399	
			0	7,205
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,217	
			0	1,217
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		35	
	ELECTRICITY		73,938	
	WATER		44,665	
	CABLE TV - LOBBY		0	
			0	118,638
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,434	
	PAINTING & DECORATING		146	
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		11,357	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,549	
	FIRE SERVICE		0	
			0	
			0	
			0	16,486
7	**OTHER**			
	SCAVENGER		7,508	
	SECURITY SERVICE		0	7,508
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	5,500	5,500

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		38	
	PURCHASED SERVICES		4,669	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	371	
	PHARMACY CONSULTANT	XVIII B 39-2	2,259	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	1,622	
			0	
			0	8,959
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES			
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES			
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,263	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	2,888	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	7,368	11,519
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	336	
				336
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	6,399	
			0	6,399
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number PRAIRIE VIEW CARE CENTER-CHARLESTON **#0040311** **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	11,975	11,975
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,771	
	ADMINISTRATIVE CONSULTANTS	XIX C	32,410	
	PROFESSIONAL FEES	XIX C	32,030	
			0	70,211
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	2,406	
	EMPLOYEE WANT ADS	XIX F	5,678	
	CONTRIBUTIONS	VI 20 XIX F		
	DUES & SUBSCRIPTIONS	XIX F	7,359	
	LICENSES & PERMITS	XIX F	1,992	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,743	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	19,178
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		1,264	
	OUTSIDE CLERICAL SERVICES		116,064	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,496	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		255	
	TELEPHONE		19,632	
			0	140,711

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	130,177	
	UNEMPLOYMENT COMPENSATION	XIX D	15,768	
	WORKERS COMPENSATION INSURANC	XIX D	45,158	
	HOSPITALIZATION INSURANCE	XIX D	95,708	
	EMPLOYEE BENEFITS - OTHER	XIX D	51	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	47,900	
	PENSION/PROFIT SHARING PLANS	XIX D	3,511	
	CHICAGO HEAD TAX	XIX D	0	338,273
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,499	1,499
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	1,422	
			0	
			0	1,422
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		5,059	5,059
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		57,818	57,818
27	**OTHER**			
	BAD DEBTS	VI 24	5,084	
			0	5,084

GRAND TOTAL COLUMN 3 OTHER 834,997

PRAIRIE VIEW CARE CENTER-CHARLESTON
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	137,608	PATIENT MEALS	102669
LESS SALES TAX	(334)	ADD EMPLOYEE MEALS	0
NET FOOD	137,274	TOTAL MEALS/YEAR	102669
TOTAL PATIENT CENSUS	34,223	NET FOOD	137274
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	102669
TOTAL PATIENT MEALS	102669	COST PER MEAL	1.34
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	365	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

PRAIRIE VIEW CARE CENTER-CHARLESTON
RECONCILIATION OF COST REPORT TO FINANCIAL STATEMENTS
12/31/2002

INCOME PER F/S									3,556,470	
	NURSING	EMPL BENEFITS	PLANT	LAUNDRY	DIETARY	GENL/ADMIN	OTHER INC/EXP	CAPITAL		SALARIES
PER COST REPORT	1,443,505	338,273	298,574	57,128	293,653	445,341	76,103	659,491		1,727,393
ADJUSTMENTS:										
EQUIPMENT RENTAL/AUTO LEASE	0		0			0		0		
CABLE TV			0			0				
CONTRACT NURSING										
INTEREST INCOME							0			
NET VENDING COMMISSIONS										
EMPLOYEE PHYSICAL EXAMS		0				0				
INSURANCE - EXECUTIVE LIFE		(47,900)				47,900				
MANAGEMENT FEES						(11,975)		11,975		
O2 INCOME										
BAD DEBTS						(5,084)	5,084			
DISCOUNTS LOST							0			
ANCILLARIES	76,802							0		
SETTLEMENT INTEREST										
RECLASSED SALARIES	0	0	0	0	0	0	0	0		
PROFIT SHARING	0	0	0	0	0	0	0	0		
PRIOR EXPENSES	0	0	0	0	0	0	0	0		
BENEFITS REBILLED	0	0	0	0	0	0	0	0		
RENT/INTEREST	0	0	0	0	0	0	0	0		
NURSE AID REIMB-STATE	0	0	0	0	0	0	0	0		
TOTAL COSTS	1,520,307	290,373	298,574	57,128	293,653	476,182	81,187	671,466	3,688,870	1,727,393
PER FINANCIAL STATEMENTS	0	0	0	0	0	0	0	0	(132,400)	0
NET INCOME (LOSS) BEFORE INCOME TAXES PER FINANCIAL STATEMENTS									0	

PRAIRIE VIEW CARE CENTER-CHARLESTON - COMPARISONS - 12/31/2002

	ref.	12/31/2002			12/31/2001			DIFF	12/31/2000		
CAPACITY DAYS		50,735			0			50,735	0		
CENSUS DAYS		34,223			0			34,223	0		
OCCUPANCY %		67.45%			#DIV/0!				#DIV/0!		
SALARIES											
TOTAL General Services	8-1	286,823	7.89%	8.38				286,823			
Social Services	12-1	28,297	0.78%	0.83				28,297			
TOTAL Health Care and Programs	16-1	1,329,571	36.56%	38.85				########			
Clerical & General Office Expenses	21-1	67,050	1.84%	1.96				67,050			
TOTAL General Administration	28-1	110,999	3.05%	3.24				110,999			
TOTAL Operation Expense	29-1	1,727,393	47.50%	50.47				########			
ADJUSTED TOTALS											
Food	2-8	137,274	3.78%	4.01				137,274			
Heat and Other Utilities	5-8	120,019	3.30%	3.51				120,019			
Maintenance	6-8	76,094	2.09%	2.22				76,094			
TOTAL General Services	8-8	650,927	17.90%	19.02				650,927			
Administrative	17-8	91,841	2.53%	2.68				91,841			
Directors Fees	18-8	0	0.00%	0.00				0			
Professional Services	19-8	42,379	1.17%	1.24				42,379			
Fees, Subscriptions, Promotions	20-8	15,237	0.42%	0.45				15,237			
License Fee-IDPA	Pg21	200	0.01%	0.01				200			
License Fee-Other	Pg21	1,792	0.05%	0.05				1,792			
Clerical & General Office Expenses	21-8	169,941	4.67%	4.97				169,941			
Employee Benefits & Payroll Taxes	22-8	313,172	8.61%	9.15				313,172			
Payroll Taxes	Pg21	145,945	4.01%	4.26				145,945			
W/C Insurance	Pg21	45,158	1.24%	1.32				45,158			
Health Insurance	Pg21	95,708	2.63%	2.80				95,708			
Inservice Training & Education	23-8	1,499	0.04%	0.04				1,499			
Travel and Seminar	24-8	3,689	0.10%	0.11				3,689			
Other Admin. Staff Transportation	25-8	7,184	0.20%	0.21				7,184			
Insurance-Prop.Liab.Malpractice	26-8	59,498	1.64%	1.74				59,498			
Other (specify):*	27-8	0	0.00%	0.00				0			
TOTAL General Administration	28-8	704,440	19.37%	20.58				704,440			
TOTAL Operation Expense	29-8	2,815,683	77.43%	82.27				########			
Real Estate Taxes	33-3	11,020	0.30%	0.32				11,020			
Real Estate Legal	Pg10	0	0.00%	0.00				0			
GRAND TOTAL COST	45-8	3,636,288	100.00%	**106.25**				########			
8-8 + (28-8 - 22-8) + 28-8*(8-1 + 28-1)/29-1		1114319.1	30.64%	**32.56**	#DIV/0!	#DIV/0!	**#DIV/0!**	#DIV/0!	#DIV/0!	#DIV/0!	**#DIV/0!**

PRAIRIE VIEW CARE CENTER-CHARLESTON - DIAGNOSTICS - 12/31/2002

This report reflects a 365-day year.
Page 3 Column 3 - Other is completely scheduled.
Total Salaries on Page 3 Line 29-1 = Page 20 Line 34-3.
Total Adj on Page 4 Line 45-7 = Page 5 Line 37.
#VALUE!
Ancillaries on Page 4 Line 39-6 = Page 16 Line 14-8.
Interest Expense on Page 4 Line 32-4 DOES NOT EQUAL Page 9 Line 15-10. Diff=-422837
Real estate tax expense on Page 4 Line 33-4 = Page 10 Line 7.
Real estate tax accrual on Page 10 Line 4 = Page 17 Line 32-1.
Depn expense on Page 4 Line 30-4 DOES NOT EQUAL Page 13 Line 82-2. Diff=-175136
Depreciation expense on Page 4 Line 30-8 = Page 13 Line 83-2.
Facility rent on Page 4 Line 34-4 DOES NOT EQUAL Page 14 Line 7-4.
#VALUE!
Nurse aide training on Page 3 Line 13-8 = Page 15 Line 9-4.
Total equity on Page 17 Line 47-1 = Page 18 Line 24-1.
Page 17 Assets = Liabilities & Capital.
Net income on Page 18 Line 7-1 = Page 19 Line 43-2.
Administrative Salaries on Page 3 Line 17-1 = Page 21-A.
Management fees on Page 3 Line 17-3 = Page 21-B.
Professional fees on Page 3 Line 19-3 = Page 21-C.
Employee benefits/Payroll taxes on Page 3 Line 22-8 = Page 21-D.
Dues, etc. on Page 3 Line 20-8 = Page 21-F.
Travel expenses on Page 3 Line 24-8 = Page 21-G.